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## JS DISEASES

ly in a dose of 25 to 30 mg/kg/day in adults (which are 2 times as used in adults) and in children (which are 2 times as used in adults).

For sulfadiazine (which is pre-76). Sulfaguanidine is also used.

1-  
COLE

le (TMP-SMX) of the two drugs. The dose is 1/2 of the usual dose, which is 12 mg/kg/day. Both drugs are active against *Neisseria gonorrhoeae*. Sulfonamides are of the inorganic acid. TMP is active against *Escherichia coli* and *Enterococcus faecalis*. Sulfa drugs are also active against *Haemophilus influenzae* type b and *Neisseria meningitidis*.

For patients allergic to sulfonamides, TMP-SMX is the drug of choice. It is effective in the treatment of *Neisseria gonorrhoeae* and *Haemophilus influenzae* type b. It is also effective in the treatment of *Escherichia coli* and *Enterococcus faecalis*. It is also effective in the treatment of *Neisseria meningitidis* and *Haemophilus influenzae* type b.

ANTIMICROBIAL  
CHEMOPROPHYLAXIS

The term antimicrobial chemoprophylaxis refers to the timely and judicious use of antimicrobial drugs to prevent infection, particularly symptomatic disease caused by microorganisms. Although antimicrobial drugs play a pivotal role in chemoprophylaxis, immunologic defenses also contribute to the process.

tion, otitis media, and acute exacerbations of chronic bronchitis.

**Adverse reactions:** The adverse reactions are the same as those listed above for sulfonamides. TMP causes identical adverse reactions to SMX but less commonly. What it does, nausea, vomiting, rash, and fever, may occur. AIDS patients have a higher incidence of adverse effects, especially neutropenia.

**Administration and dosage:** The oral dosage in adults is 2 regular-strength tablets (each tablet contains 80 mg TMP and 400 mg SMX) or one double-strength tablet (160 mg TMP and 800 mg SMX) bid. The usual oral dosage in children is 8 mg/kg/day and 40 mg/kg/day SMX daily in 2 divided doses. The IV dosage in adults and children is 12 mg/kg/day TMP and 40 to 60 mg/kg SMX daily in 4 divided doses. Single-dose therapy with 1 or 2 double-strength tablets has been successfully for lower UTI in women.

Much higher dosages (20 mg/kg/day TMP and 100 mg/kg/day SMX in 4 divided doses) are used in the treatment of *P. carinii* pneumonia. Much lower dosages (40 mg TMP and 200 mg SMX each night) are used for prophylaxis of UTI. For prophylaxis of *P. carinii* pneumonia, 160 mg TMP and 800 mg SMX daily or 3 days/wk (for children, 5 mg/kg/day in 2 divided doses daily or 3 times/wk) is used.

## Trimethoprim

For patients allergic to sulfonamides, TMP-SMX has been used mainly in the treatment of chronic bacterial prostatitis and in prophylaxis and treatment of UTI. The pharmacology and adverse effects are listed under TMP-SMX, above. The dosage in adults for treatment of UTI is 100 mg po q 12 h or 200 mg once daily.

Successful prophylaxis requires either target pathogens that are unlikely to develop resistance to the drugs used or clinical situations in which the duration of risk is measured in weeks or days, thus permitting the effective use of antimicrobial drugs before resistance can emerge.

## Prophylaxis Against Exogenous Pathogens

Prevention of infection by exogenous pathogens, organisms that are not usually part of the normal human flora, may involve destroying microbes before attachment to host cells, modifying the microbes to prevent attachment, or eradicating colonization before either tissue invasion or toxin production begins. Indications for prophylaxis include prevention of infections caused by *Escherichia coli* in patients with a history of rheumatic fever or rheumatic heart disease (see Ch. 270) and in those with recurrent cellulitis (see Ch. 112). Patients with animal and human bites are frequently seen. The choice of drug is controversial, as amoxicillin 500 mg/clavulanic acid 125 mg bid for 5 days is often recommended for dog, and human bites. Amoxicillin 500 mg qid or doxycycline 100 mg bid po is effective in preventing Lyme disease after tick bites; however, prophylaxis is seldom indicated because the risk of infection is generally low (see LYME DISEASE in Ch. 157).

Although *Neisseria meningitidis* and *Haemophilus influenzae* type b may occasionally colonize the upper respiratory tract of healthy persons, some persons exposed to patients with meningitis or other invasive diseases caused by these bacteria warrant prophylaxis. Household contacts, children in contact in day care centers, and others exposed to respiratory secretions of patients with invasive meningococcal disease (eg, physicians performing mouth-to-mouth resuscitation) should receive rifampin 600 mg po bid for 2 days if > 12 yr of age. Pediatric dosage is 5 mg/kg q 12 h po for 2 days if < 12 yr old and 10 mg/kg q 12 h po (maximum 400 mg) for 2 days if 1 mo to 12 yr old. Ceftriaxone 125 mg IM for children < 12 yr and ceftriaxone 250 mg IM for adults are other options. Alternatively, a single dose of ciprofloxacin 500 mg po can be given to adults > 18 yr. If unvaccinated household contacts of patients with invasive disease

## CHAPTER 153 - ANTIBACTERIAL DRUGS / 1123

caused by *H. influenzae* type b are children < 4 yr of age, all household members except pregnant women should receive oral therapy with rifampin 20 mg/kg (maximum 600 mg) daily for 4 days if > 1 mo old and 10 mg/kg for 4 days if < 1 mo old. This regimen should also be used with concurrent vaccine administration for susceptible children in day care centers, especially when two or more cases occur within 60 days and contacts include unvaccinated children < 2 yr old.

Persons traveling to endemic areas for malaria should receive prophylaxis (see Ch. 161). Although numerous studies have demonstrated that antimicrobial prophylaxis can reduce the frequency of travelers' diarrhea when traveling to high-risk areas for short durations, prophylaxis is controversial because of emerging resistance. Successful prophylaxis for this indication requires some knowledge of local susceptibility patterns for the target pathogens, usually toxin-producing strains of *Escherichia coli*. Most authorities prefer to reserve antimicrobial therapy for persons who develop diarrhea. For persons who must have prophylaxis, ciprofloxacin 500 mg/day po, norfloxacin 400 mg/day po, or two bismuth subsalicylate tablets po qid are effective. In some areas with low rates of antimicrobial resistance, oral trimethoprim-sulfamethoxazole (TMP-SMX) 160 mg/day (TMP) and 800 mg/day (SMX) or doxycycline 100 mg/day may be effective.

Antimicrobial prophylaxis is also used to prevent some viral infections. Prophylaxis with amantadine or rimantadine is effective during influenza A epidemics (see Ch. 162). Similarly, those sustaining parenteral exposures to blood or certain other body fluids from patients infected with HIV or those exposed to laboratory stocks of HIV may require prophylaxis with antiretroviral drugs (see Ch. 163).

Certain other uses of chemoprophylaxis are recommended, even though evidence from clinical trials is lacking. For the prevention of plague in exposed persons and laboratory workers, tetracycline 30 mg/kg/day po in 4 divided doses for 10 days or streptomycin 1 g IM daily for 1 wk appears to be effective. For prevention of pertussis in close contacts or colonized persons, erythromycin in an oral dose of 12.5 mg/kg qid (not to exceed 2 g/day) for 14 days is used. Chemoprophylaxis is widely used to prevent sexually transmitted diseases in the contacts of

## 1124 / SECTION 13 - INFECTIOUS DISEASES

active cases as well as in rape victims. Sexual partners of patients with gonorrhea, chancroid, lymphogranuloma venereum, nongonococcal urethritis, syphilis, trichomoniasis, scabies, pediculosis pubis, and infection caused by *Chlamydia trachomatis* receive standard therapeutic courses of the drugs normally used to treat these infections whether symptoms are present or not (see Ch. 164). Rape victims are treated with single doses of ceftriaxone 250 mg IM and metronidazole 2 g po and with doxycycline 100 mg po bid for 7 days. A single topical application of a 1% silver nitrate, 0.5% erythromycin ophthalmic ointment, or 1% solution of tetracycline ophthalmic ointment is used to prevent gonococcal and chlamydial infections in the eyes of newborns (see Ch. 260). Penicillin V, 20 mg/kg/day in 2 divided doses for children < 5 years and 250 mg po bid for children > 5 years, or amoxicillin, 125 mg po bid for children < 5 years and 250 mg po bid for children > 5 yr, is given to children with sickle cell disease or hypogammaglobulinemia or after splenectomy to prevent overwhelming pneumococcal infections. Although prophylaxis is controversial, some authorities recommend it until 5 yr of age or 5 yr after surgical removal of the spleen, whichever is longer. The 250-mg bid oral doses of penicillin V and amoxicillin have also been used in adults after splenectomy, but their efficacy is undetermined. To reduce infection rates in patients with chronic granulomatous disease, TMP-SMX in an oral dose of 8 mg/kg (TMP) and 40 mg/kg (SMX) bid for children and 80 mg/kg (TMP) and 400 mg/kg (SMX) for adults is widely used. Specific prophylactic guidelines exist for persons with AIDS and other causes of immunodeficiency.

#### Prophylaxis Against Endogenous Pathogens

Prevention of infection by endogenous pathogens, transient or permanent constituents of the normal human flora, usually involves prolonged treatment of chronically colonized persons to prevent spread of bacteria from the site of colonization to more vulnerable sites. For example, adult patients with recurrent skin infections caused by *S. aureus* have fewer infections while receiving orally administered clindamycin in a dose of

150 mg once daily. Hemodialysis patients with nasal carriage of *S. aureus* and a history of recurrent infections caused by this organism have reduced rates of infection if orally administered rifampin in a dose of 600 mg bid for 5 days plus topical bacitracin nasal nares for 7 days every 3 mo if nasal cultures are positive for *S. aureus*. Mupirocin applied transnasally may substitute for bacitracin in this regimen.

Children with recurrent otitis media experience fewer recurrences when treated prophylactically. Likewise, women with more than three UTIs per year have lower infection rates when treated prophylactically. Patients with compromised immune tracts and frequent recurrences of *Escherichia coli* infection appear to have reduced rates of infection when taking TMP-SMX, ciprofloxacin 500 mg bid po.

In other cases, only a day or two of antimicrobial therapy is required to prevent infection. *Streptococcus agalactiae* infection in pregnant women and newborns is reduced with intrapartum penicillin or ampicillin therapy. Generally, only small doses of antimicrobial drugs are recommended to prevent endocarditis in patients with valvular or congenital heart disease when undergoing dental, surgical, or other procedures that are likely to induce bacteremia (see Ch. 208).

Patients undergoing intensive chemotherapy for malignant disease who have absolute neutrophil counts < 500 cells/ $\mu$ L of blood are at high risk for bacterial infection caused by resident flora of the GI tract. Although controversial, prophylactic antimicrobial therapy has been used to reduce the rate of infection during the neutropenic phase. Antimicrobial resistance patterns and trends in some medical centers argue against this approach to prophylaxis. When used, prophylactic therapy for neutropenic patients includes either oral nystatin (200,000-U lozenge qid or 500,000-USP tablet qid) or clotrimazole (10 mg tablet, 5 times/day) to combat *Candida* and other yeasts plus oral antimicrobials. Oral penicillin V 500 mg bid is taken with either SMX/TMP 1600/320 mg bid or ciprofloxacin 500 mg bid, or ofloxacin 400 mg bid, or ciprofloxacin 400 mg bid. Adding fluconazole to either regimen is beneficial.

150 mg once daily. Hemodialysis patients with nasal carriage of *S. aureus* and a history of recurrent infections caused by this organism have reduced rates of infection with orally administered rifampin in a dose of 300 mg bid for 5 days plus topical bacitracin ointment for 7 days every 3 mo if nasal cultures are positive for *S. aureus*. Mupirocin ointment transnasally may substitute for bacitracin in this regimen.

Children with recurrent otitis media experience fewer recurrences when treated prophylactically. Likewise, women with more than three UTIs per year have reduced infection rates when treated prophylactically. Patients with compromised immune systems and frequent recurrences of ascending infection appear to have reduced rates of infection when taking TMP-SMX or ciprofloxacin 500 mg bid po.

In other cases, only a day or two of antimicrobial therapy is required to prevent infection. *Streptococcus agalactiae* infections in pregnant women and newborns can be reduced with intrapartum penicillin or ampicillin therapy. Generally, only three doses of antimicrobial drugs are recommended to prevent endocarditis in patients with valvular or congenital heart disease when undergoing dental, surgical, or dental procedures that are likely to induce bacteremia (see Ch. 208).

Patients undergoing intensive chemotherapy for malignant disease who have absolute neutrophil counts < 500 cells/ $\mu$ L for ≥ 5 days are at high risk for bacterial infections caused by resident flora of the GI tract. Although controversial, prophylactic antimicrobial therapy has been used to suppress the endogenous flora of the bowel and reduce the rate of infection during the neutropenic phase. Antimicrobial resistance patterns and trends in some medical centers argue against this approach to prophylaxis. When used, prophylactic therapy for neutropenic patients includes either oral nystatin (200,000-U lozenge qid or 500,000-U solution or tablet qid) or clotrimazole (10 mg troches 5 times/day) to combat *Candida* sp and other yeasts plus oral antimicrobial drugs. Oral penicillin V 500 mg bid is taken with either SMX/TMP 1600/320 mg bid or a fluoroquinolone—ciprofloxacin 500 mg bid, ofloxacin 400 mg bid, or ofloxacin 400 mg bid. Adding fluconazole to either regimen is not beneficial.

In patients undergoing allogenic bone marrow transplantation, similar approaches are used to prevent infection during the prolonged phase of neutropenia before marrow engraftment.

Critically ill patients in ICUs who require intubation and mechanical ventilation for more than a few days are at high risk for developing bacterial pneumonia. Selective decontamination of the digestive tract, which is used extensively in Europe, combats this risk with topical and systemic antimicrobial therapy. It is designed to prevent oropharyngeal and GI colonization by aerobic gram-negative bacilli and *Candida* sp. In most studies, a paste containing polymyxin B, tobramycin or gentamicin, and amphotericin B or nystatin has been applied to the oral mucosa qid for the duration of intubation, and solutions of the same antimicrobial drugs have been administered orally or through a nasogastric tube several times a day. Cefotaxime 1 to 2 g IV q8h has also been administered for the first 5 days. Although such regimens have reduced infection rates in several studies, especially those for nosocomial pneumonia, there is no consensus recommending its use in the USA.

## CHAPTER 153 – ANTIBACTERIAL DRUGS / 1125

### Prophylaxis in Surgery

Antimicrobial drugs are used perioperatively to prevent endogenous flora from gaining entry into normally sterile body sites. As a rule, prophylaxis is beneficial in so-called clean procedures only when prosthetic material or devices are being inserted and in clean-contaminated procedures, which are defined by transections of respiratory, GI, or GU tract mucosal surfaces. All of these surfaces are populated by the host's normal flora, which inevitably contaminate the wound and cause a high incidence of wound infections if prophylactic antimicrobial drugs are not administered.

Selection of antimicrobial drugs is based on the bacterial most likely to contaminate the wound during a specific procedure. Commonly recommended prophylaxes for various procedures are listed in TABLE 153-3. These recommendations may need to be modified in light of patient allergies, local resistance patterns, and local infection rates.

To effectively prevent surgical site infections, antimicrobial drugs are usually administered IV at the induction of anesthesia to ensure adequate concentrations in the wound when the first incision is made. De-

TABLE 153-3. ANTIMICROBIAL PROPHYLAXIS IN SURGERY

Category and Procedure	Adult Dosage*
<b>Neurosurgical</b>	
Craniotomy—high risk only, eg, re-explorations, microsurgery, and entry into sinuses or nasopharynx	Vancomycin 1 g IV and gentamicin 1.5 mg/kg IV preop; or cefazolin, 1 g IV preop
CSF shunt placement—only in hospitals with high infection rates (15–20%)	Trimethoprim 160 mg IV and sulfamethoxazole 800 mg IV preop and q 12 h for 3 doses; or vancomycin 10 mg and gentamicin 3 mg injected into cerebral ventricle
<b>Ophthalmic</b>	
Extraction of lens, including insertion of prosthesis	Gentamicin, tobramycin, or neomycin-gramicidin-polymyxin B drops over 2–24 h; and cefazolin 100 mg subconjunctivally at end of procedure
<b>Otolaryngologic</b>	
Major head and neck surgery involving mucosa of oral cavity or pharynx	Cefazolin 1–2 g IV; or clindamycin 600–900 mg IV ± gentamicin 1.5 mg/kg IV preop and q 8 h for 2 doses
<b>Cardiac</b>	
Median sternotomy, coronary artery bypass grafting, valve surgery, and pacemaker insertion	Cefazolin 2 g or cefuroxime 1.5 g IV preop and q 4–6 h intraoperatively; or vancomycin 1 g preop

Table continues on the following page.

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TABLE 153-3. ANTIMICROBIAL PROPHYLAXIS IN SURGERY (Continued)

Category and Procedure	Adult Dosage*
<b>Noncardiac thoracic</b> Pneumonectomy, lobectomy, and other resections or esophageal operation	Cefazolin 1-2 g IV preop and q 6 h for 24 h; vancomycin 1 g IV preop
<b>Abdominal</b> Gastrooduodenal—with hemorrhage, malignancy, obstruction, and other high-risk features	Cefazolin 1-2 g IV preop or clindamycin and gentamicin 120 mg IV preop
Gastric bypass	Cefazolin 1-2 g IV preop
Percutaneous gastrostomy	Cefazolin 1-2 g IV preop
Biliary tract (including ERCP)—with acute symptoms, previous surgery, jaundice, and other high-risk features	Cefazolin 1-2 g IV preop; or gentamicin 120 mg IV preop and q 8 h for 3 doses
Appendectomy	Cefoxitin or cefotetan or cefmetazole IV preop and q 6 h for 3 doses if not performed or metronidazole 500 mg and gentamicin 120 mg/kg preop
<b>Colorectal</b>	Neomycin 1 g and erythromycin base 1 g po 2, and 11 PM on day before surgery if no parenteral agent(s) listed below; if enteric cefoxitin or cefotetan or cefmetazole IV, and q 4 h for 3 doses; or metronidazole 500 mg IV and gentamicin 1.7 mg/kg IV preop and for 3 doses
<b>Obstetric-gynecologic</b> Cesarian section—high risk only, e.g., premature rupture of membranes Abortion—2nd trimester instillation Abortion—1st trimester, with history of pelvic inflammatory disease, gonorrhea, or multiple partners Hysterectomy, vaginal or abdominal	Cefazolin 1 g IV after clamping cord and 6-12 h later
<b>Orthopedic</b> Arthroplasty, including replacements	Cefazolin 1 g IV preop and q 6 h for 2 doses
Open reduction of fractures	Penicillin G 1-2 million U IV preop and 3 h, or doxycycline 100 mg po before procedure, 200 mg 1/2 h afterward
Lower limb amputation	Cefazolin 1 g IV preop and q 6 h for 2 doses; doxycycline 200 mg IV preop
<b>Vascular</b> Lower extremity or abdominal arterial surgery; lower extremity amputation for ischemia	Cefazolin 1-2 g IV preop and q 6 h for 24 h; vancomycin 1 g IV preop and 12 h after procedure
<b>Urologic</b> Prostatectomy—if bacteruria is present Penile prosthesis insertion	Cefazolin 1 g IV preop or other agent selected basis of susceptibility tests Cefazolin 1 g IV preop

\*Agents, dosages, routes, and frequencies given are representative of current expert recommendations. Cefazolin remains highly favored because of its spectrum of bactericidal activity, long half-life, low cost, and low toxicity. Alternatives are primarily for patients with beta-lactam allergies.  
preop = preoperative.

Adapted from Kernodle DS, Kaiser AB: "Postoperative infections and antimicrobial prophylaxis," in *Principles and Practice of Infectious Diseases*, ed. 4, edited by GL Mandell, JE Bennett, and R Dolin. New York: Churchill Livingstone, 1995, pp. 2742-2756 and from "Antimicrobial prophylaxis in surgery." *The Medical Letter* 39:97-102, 1997.

**PHYLAXIS IN SURGERY (Continued)****Adult Dosage\***

zolin 1-2 g IV preop and q 6 h for 24 h; or  
uncomycin 1 g IV preop

zolin 1-2 g IV preop or clindamycin 600 mg  
d gentamicin 120 mg IV preop

zolin 1-2 g IV preop  
zolin 1-2 g IV preop  
zolin 1-2 g IV preop; or gentamicin 80 mg  
IV preop and q 8 h for 3 doses

ctin or cefotetan or cefmetazole 1-2 g IV  
preop and q 5 h for 3 doses if not performed;  
metronidazole 500 mg and gentamicin 1.7 mg/kg  
IV preop

yclin 1 g and erythromycin base 1 g IV preop  
and 11 PM on day before surgery if elected;  
enteral agent(S) listed below; if emergent:  
yclin or cefotetan or cefmetazole IV preop  
q 4 h for 3 doses; or metronidazole 500 mg  
and gentamicin 1.7 mg/kg IV preop and q 8 h for  
3 doses

lin 1 g IV after clamping cord and 6 h later  
lin 1 g IV preop and q 6 h for 2 doses  
lin G 1-2 million U IV preop and 3 h later  
oxycline 100 mg po before procedure  
and 1/2 h afterward  
lin 1 g IV preop and q 6 h for 2 doses; or  
oxycline 200 mg IV preop

in 1-2 g IV preop and q 6 h for 3 doses;  
uncomycin 1 g IV preop  
in 1 g IV preop and q 6 h for 3 doses  
in 2 g IV preop and q 6 h for 4 doses

in 1-2 g IV preop and q 6 h for 24 h; or  
uncomycin 1 g IV preop and 12 h after procedure

in 1 g IV preop or other agent selected on  
of susceptibility tests  
in 1 g IV preop

representative of current expert recommendations  
bactericidal activity, long half-life, low cost and  
lactam allergies

ections and antimicrobial prophylaxis," in *Principles of  
JL Mandell, JE Bennett, and R Dolin. New York:  
Microbial prophylaxis in surgery," The Medical Letter*

pending on the duration of the procedure  
and the pharmacokinetics of the drugs, ad-  
ditional doses may be required intraopera-  
tively. The need for additional doses after the  
wound has been closed is highly controver-  
sial but is recommended by many authorities  
(see TABLE 153-3). The prophylaxis should  
not be continued > 24 h unless an active  
infection was discovered during surgery.

**Prophylaxis Against Dormant  
or Latent Pathogens**

Prevention of infection by dormant or lat-  
ent pathogens, which are microorganisms  
already residing in the human host but not  
currently causing disease, requires either  
microbial eradication before immunologic  
defenses wane and allow the organisms to  
proliferate, or ongoing suppression of the  
remaining organisms, thereby precluding  
their multiplication and dissemination. For  
example, prophylaxis with acyclovir dram-  
atically reduces the rate and severity of

**CHAPTER 154 - ANTIVIRAL DRUGS / 1127**

recurrences in persons with genital herpes  
who are subject to frequent attacks (see Ch.  
164). Similarly, prophylactic therapy with  
isoniazid greatly reduces the likelihood of  
symptomatic disease in persons with latent  
TB infection (see Ch. 157).

Antimicrobial therapy is frequently used  
to prevent infections by latent or dormant  
pathogens in immunocompromised patients.  
Prophylaxis with TMP-SMX prevents *Pneu-  
mocystis carinii* pneumonia in persons  
undergoing intensive chemotherapy for  
various types of malignant disease or trans-  
plantation procedures. TMP-SMX, inhaled  
pentamidine, dapsone, and other drugs are  
used to prevent *P. carinii* pneumonia in pa-  
tients with AIDS (see Ch. 163). Also, patients  
with AIDS, depending on their CD4<sup>+</sup> lym-  
phocyte counts and exposures, often receive  
prophylaxis to prevent symptomatic disease  
caused by opportunistic infections (see Ch.  
163). Similar targets for prophylaxis are en-  
countered in transfusion and solid organ  
transplantation procedures (see Ch. 149).

**154 / ANTIVIRAL DRUGS**

The development of drugs against HIV has  
resulted in a dramatic expansion of new antiviral  
chemotherapeutic drugs. The applica-  
tions of some of these drugs are being eval-  
uated for other viral infections such as  
hepatitis B virus (HBV). Other advances in-  
clude development of drugs with improved  
bioavailability for common infections such as  
herpes simplex virus (HSV) and varicella-  
zoster virus (VZV).

Chemotherapeutic intervention can occur  
before or at the time of viral particle attach-  
ment to host cell membranes, during un-  
coating of viral nucleic acids, by inhibiting a  
cellular receptor or factor required for viral  
replication, or by blocking specific, virus-  
coded enzymes and proteins produced in the  
host cells that are essential for viral replica-  
tion but not for normal host cell metabolism.

**Idoxuridine**

Iodoxuridine (IDU) acts by irreversibly re-  
placing thymidine in newly synthesized DNA

and producing an abnormal and essentially  
nonfunctional DNA molecule. The drug acts  
on viral and host cell DNA and is *highly toxic to host cells*. Because of its high systemic  
toxicity, IDU has been limited to topical ther-  
apy of herpes simplex keratoconjunctivitis.  
Two topical ophthalmic preparations are  
available. One drop of a 0.1% solution is in-  
stilled conjunctivally q 1 h during waking  
hours and q 2 h at night. Treatment should  
be continued for 5 to 7 days after complete  
healing to lessen the chance of recurrence.  
IDU may cause irritation, pain, pruritis, and  
inflammation or edema of the eyelids; rare  
allergic reactions and photophobia have also  
been reported.

**Vidarabine**

Vidarabine (adenine arabinoside, ara-A)  
interferes with viral DNA synthesis and is  
effective in the treatment of HSV infections.  
Vidarabine appears less susceptible to the  
development of drug-resistant viral strains

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